General Information

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Your Insurance Benefits: Help When You Need It Most

Your insurance, offered through the Employee Insurance Program, provides a financial safety net when you are ill or injured. Several health plans are available.

Through the **State Health Plan**, you may enroll in the Standard Plan, the Savings Plan or, if you are a retiree and eligible for Medicare, the Medicare Supplemental Plan.

Three **Health Maintenance Organizations** are offered:

- BlueChoice HealthPlan is available statewide.
- CIGNA HMO is available in all counties **except** Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.
- MUSC Options is available **only** in Berkeley, Charleston, Colleton and Dorchester counties.

For more information on retiree health insurance options, including the Medicare Supplemental Plan, refer to the Retirement/Disability Retirement chapter, which begins on page 169.

Active employees who enroll in a health plan receive Basic Life Insurance and Basic Long Term Disability Insurance at no charge.

Eligible employees and retirees may also enroll in the State Dental Plan and in Dental Plus. Dental Plus supplements State Dental Plan coverage. It pays a higher amount for the same services covered by the State Dental Plan except orthodontia, which Dental Plus does not cover.

ENROLLING IN A HEALTH OR DENTAL PLAN

ELIGIBILITY

An eligible active employee:

- Is employed by the state, a school district or a participating *local subdivision* and
- Works in a permanent, full-time position and
- Receives compensation from the state, a school district or a participating local subdivision.

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of the councils of participating counties or municipalities, who also participate in the S.C. Retirement Systems (SCRS), and permanent, part-time teachers are considered employees for insurance purposes. Members of other governing boards are not eligible for coverage. If you work for more than one *participating group*, please contact your benefits administrator for further information.

Retiree insurance eligibility is explained on pages 171-172.

A *local subdivision* is any *participating group* other than a state agency or a public school district. Examples of local subdivisions include: counties, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, municipalities, recreation districts, hospital districts and councils of government. Since 1985, the General Assembly has passed legislation extending voluntary participation in the state insurance benefits program to certain local subdivisions. For a local subdivision to be eligible to participate in the state insurance benefits program, it must fall within one of the categories established by statute (Section 1-11-720 of the 1976 S.C. Code of Laws, as amended).

An eligible dependent spouse:

- Is a lawful spouse, or
- A former spouse who is required to be covered by a divorce decree, but not both spouses.

A spouse who is eligible for coverage as an employee of a participating group may not be covered as a dependent. A spouse who is a part-time teacher may be covered as an employee or as a dependent, but not as both.

An eligible dependent child:

- Is an unmarried child under age 19
- Must be principally dependent (more than 50 percent) on the subscriber for maintenance and support
- Must be the natural child, adopted child, stepchild, foster child or child for whom the subscriber has legal custody and
- Must reside in the subscriber's home in a parent-child relationship unless the subscriber has been directed to provide coverage by a court order.

For information about eligibility of dependents age 19 and over, see pages 14-16.

Initial Enrollment

If you are an eligible employee or retiree of a *participating group* in South Carolina, you can enroll in a health plan and the dental plan within 31 days of the date you are hired or the date you retire. A *participating group* is a state agency, public school district, county, municipality or other group that is authorized by statute to participate in, and is participating in, the state insurance plan.

To enroll in a health or dental plan, you complete the required forms, including a *Notice of Election (NOE)*. An *NOE* is used to: enroll in benefits; add or delete dependents; or change a subscriber's coverage level, beneficiary, name or address. Coverage is not automatic. You can also enroll your eligible dependents.

To enroll in Dental Plus, you must be enrolled in the State Dental Plan. You must cover the same family members under both plans.

After you enroll, please check your payroll stub to make sure the correct premiums are deducted. Your health and dental coverage will continue from one year to the next as long as you are a full-time, permanent employee or an eligible retiree. Your coverage begins on the first day of the month if you are *actively at work* on the first working day of the month.

An employee is considered *actively at work* on his employer's scheduled workday if he is performing the regular duties of his occupation. He may be working at his usual work place or at another place, if he is required to travel. An employee is considered actively at work on a paid vacation day or on his employer's normal holidays only if he was actively at work on the last day before the vacation day or holiday.

If you are not actively at work on the first working day of the month, your coverage starts on the first day of the next month. Your enrolled dependents' coverage begins on the same day your coverage begins.

INSURANCE CARDS

If you enroll in the State Health Plan Standard Plan, Savings Plan or Medicare Supplemental Plan, BlueCross BlueShield of South Carolina will send you insurance cards for you and your eligible dependents. BlueChoice HealthPlan, CIGNA Healthcare and MUSC Options will mail insurance cards to their members. Dental and Dental Plus subscribers will receive insurance cards from BlueCross BlueShield of South Carolina.

All insurance cards for all family members are issued in the subscriber's name only.

Benefits Identification Number

The Employee Insurance Program gives each subscriber an eight-digit Benefits Identification Number (BIN). This unique number is used instead of a Social Security Number in e-mails and written communication between EIP and you and your dependents. It is designed to make your personal information more secure.

When you contact EIP, you may give your SSN or your BIN, and the Customer Service staff will be able to assist you.

BlueCross BlueShield of South Carolina, BlueChoice HealthPlan and MUSC Options put your BIN on your identification card. The BIN is also used on Dental Plus cards. CIGNA gives its members another secure number. If you are not enrolled in a program that uses the BIN, EIP will send you a letter giving you your number.

Keep a record of your BIN in a safe place. Active employees need it to use MyBenefits, EIP's online enrollment system. However, you can also get your BIN through MyBenefits. For more information, see page 22.

ANNUAL AND OPEN ENROLLMENT

Every October, you may make changes in your **health coverage** without regard to special eligibility situations.

- During *annual enrollment,* eligible employees, retirees, survivors and COBRA subscribers may change health plans only. This includes changing to or from the Medicare Supplemental Plan, if you are retired.
- During *open enrollment*, which occurs in odd-numbered years, eligible subscribers may enroll in or drop their own health coverage and add or drop eligible dependents. You may also change your **dental coverage**.

Changing Plans or Coverage

You can change to or from the Savings Plan, the Standard Plan, a health maintenance organization (HMO) or the Medicare Supplemental Plan (if you are retired) only during October enrollment periods. There may be exceptions to this rule. Contact your benefits administrator for details if you are an active employee or if you are a retiree, a survivor or COBRA subscriber of a local subdivision. Retirees, survivors and COBRA subscribers of other employers should contact EIP.

Retirees and survivors and their eligible dependents who are enrolled in a health plan may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility or during annual or open enrollment.

If you are retired and eligible for Medicare, you may not enroll in the Savings Plan. Active employees of any age and retired employees who are not eligible for Medicare can enroll in the Savings Plan.

You can add or drop State Dental Plan and Dental Plus coverage only during open enrollment, which is in October of odd-numbered years, or within 31 days of a special eligibility situation.

Other changes you may make in your insurance coverage are explained in *The Insurance Advantage,* which you receive each September. Changes made during open or annual enrollment become effective the following January 1.

Pre-Existing Condition Exclusions

Most of the health plans offered through EIP exclude coverage for a *pre-existing condition*. This means that if you have a medical condition before coming to the plan, you may have to wait a certain period of time

before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. The pre-existing exclusion does not apply to pregnancy nor to a child who is enrolled within 31 days of birth, adoption or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late entrant) from your enrollment date. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of more than 62 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you must present to your benefits administrator a creditable coverage letter or a letter on letterhead from your previous employer that includes the dates coverage began and ended, the names of all individuals covered and the types of coverage.

The State Dental Plan and Dental Plus do not have pre-existing condition exclusions.

Late Entrants

If you do not enroll within 31 days of the date you begin employment, retire or experience a special eligibility event, you cannot enroll yourself or your eligible dependents until the next open enrollment period. Open enrollment is held in October of odd-numbered years, and your coverage will take effect the following January 1. As late entrants, you and your dependents will be subject to an 18-month pre-existing condition exclusion period, which may be reduced by prior creditable coverage.

SPECIAL ELIGIBILITY SITUATIONS

If you decline enrollment for yourself or your eligible dependents (including your spouse), because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents for coverage at a later date if you or your dependents involuntarily lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must complete a Notice of Election (NOE) form within 31 days of the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent. However, you must complete a Notice of Election (NOE) form within 31 days of the date of the marriage, birth, adoption or placement for adoption. A salary increase does not create a special eligibility situation.

If you are an active employee and eligible to change your health, dental or Optional Life Insurance coverage due to a special eligibility situation, you also may enroll in or drop the Pretax Group Insurance Premium Feature.

Marriage

If you, as a covered subscriber, wish to add a dependent spouse because you marry, you can do so by completing a Notice of Election (NOE) form within 31 days of the date of your marriage. Coverage becomes effective with the date of marriage. You cannot cover your spouse as a dependent if he is eligible, or becomes eligible, for coverage as an employee or as a retiree of a participating group. If you do not add your spouse within 31 days of the date of marriage, you cannot add him until the next open enrollment period or within 31 days of a special eligibility situation.

Legal Separation

If you and your covered spouse separate, your spouse may remain on your health, dental and Dependent Life/Spouse coverage until the divorce is final.

To drop your spouse when you separate, you must submit a copy of a court order signed by the judge to your benefits administrator or to the Employee Insurance Program if you are a covered retiree. It must state that the divorce is in progress, and it must be attached to a Notice of Election form. Your spouse's coverage will end the last day of the month after the date of separation, if you drop your spouse within 31 days of separation. Otherwise coverage will end the first of the month after the date you request it.

If you reconcile with your spouse after you drop health insurance coverage for your spouse, coverage cannot be reinstated until the next open enrollment period or a special eligibility situation. He will be considered a late entrant. As such, he will not be eligible for coverage for pre-existing conditions until 18 months after enrollment. For more information, see page 11.

You may re-enroll your spouse in Dependent Life/Spouse year-round if you submit medical evidence of good health and it is approved by The Hartford. Dental coverage can be reinstated during the next open enrollment period or within 31 days of a special eligibility situation.

Divorce

If you, as a subscriber, divorce, you must drop your spouse from your coverage by completing a Notice of Election form and submitting **a complete copy** of the divorce decree within 31 days of the date the divorce decree is signed. Your divorced spouse's coverage ends the last day of the month after the divorce decree is signed. You can continue to cover your eligible dependent children if they live with you and you are financially responsible for them.

You may continue to provide health, dental and Dependent Life coverage for your former spouse only if the Family Court requires that you do so. You must give a complete copy of the Family Court decree or a complete copy of the divorce decree, as well as an NOE, to your benefits administrator, who will send both to EIP. The document must list the programs under which your former spouse must be covered. Retirees of state agencies, schools and institutions of higher education, survivors and COBRA subscribers should notify EIP. Retirees of local subdivisions should notify their benefits administrator.

If you remarry, you can cover your divorced spouse or your current spouse, but you cannot cover both under any EIP program. Dependent spouses who lose coverage due to a qualifying event may be eligible to continue coverage under COBRA. For more information, you must contact your benefits administrator or EIP as soon as possible, but **no later than** within 60 days of the event or from when coverage would have been lost due to the event, whichever is later.

Adding Children

Eligible children may be added by completing an NOE **within 31 days** of the date of birth, gaining legal custody, adoption or placement for adoption. **Children must be listed on your NOE to be covered, even if you already have Full Family or Employee/children coverage. Notification to Medi-Call of the delivery of your baby does not add the baby to your health insurance.**

To add adopted children to your policy, you must submit a copy of the legal adoption documentation from the court, verifying the completed adoption; or a letter of placement from an attorney, adoption agency or the S.C. Department of Social Services (DSS) verifying the adoption is in progress, as well as an NOE. An adopted child will be covered on the date of adoption or when the child has been placed in a subscriber's home, a petition for adoption has been filed and the petitioner has temporary custody of the child.

To verify custody or guardianship of a child, you must submit a copy of the court order or other legal documentation from a placement agency or DSS granting you custody or guardianship of the child or foster child. The documents must verify that you, the subscriber, have guardianship responsibility for the child and not just financial responsibility.

If a court order is issued requiring you to cover your dependent child, you must notify your employer and EIP within 31 days of the date the court order was issued and elect coverage for that child and yourself, if you are not already enrolled.

If you and your spouse are both covered employees, only one of you can cover your children.

Gaining Other Coverage

If you or your dependents gain other group coverage, you have 31 days to cancel your coverage by completing an NOE and returning it to your benefits office with proof of the other coverage. To document that you have gained coverage, you must present a letter on company letterhead that includes dates of coverage, names of all individuals covered and types of coverage gained.

If you fail to cancel coverage within 31 days, you must wait until the next open enrollment period. For more details, contact your benefits administrator or EIP.

Involuntary Loss of Other Coverage

If you or your dependents are covered under another health or dental plan and you lose that coverage involuntarily because it was discontinued or the covered employee left his job, you have 31 days from the last day of coverage to enroll through EIP. To enroll, you must complete an NOE and return it to your benefits office. To document that you have lost coverage, you must attach a creditable coverage letter or a letter on company letterhead that includes dates of coverage, names of all individuals who lost coverage, the types of coverage and the reason for the loss. Dependents must be listed on the NOE to be covered. Only family members who actually lost coverage may enroll. If you fail to enroll within the 31 days, you must wait until the next open enrollment, which occurs in October of odd-numbered years, or within 31 days of a special eligibility situation.

COVERAGE OF DEPENDENT CHILDREN AGE 19 AND OLDER

Full-time Students, Ages 19-24

You may cover your dependent children, ages 19-24, who are full-time students. They must meet these requirements:

- Students must be enrolled in and attending an accredited high school, vocational/trade school or college/university **full-time**, as defined by the institution they attend.
- While summer school is not required for maintaining student status, dependents who enroll in summer school full-time may become eligible. However, they will lose eligibility if they do not re-enroll full-time the next semester/quarter.
- Enrollment in adult education night classes and correspondence courses is not considered full-time attendance. Internet courses from the accredited educational institution the student is attending do count toward the hours needed for him to be considered a full-time student.

If you are an active employee or a retiree, EIP will send a Student Certification letter to your benefits administrator approximately 90 days before your dependent's 19th birthday. Your BA will forward the letter to you. To continue coverage, this letter must be completed and returned to EIP within 31 days of the child's 19th birthday. You must also include a statement on letterhead from the educational institution he is attending that confirms he is a full-time student as of the date of his 19th birthday and gives his dates of enrollment. Evidence of pre-registration is not adequate. If the child's 19th birthday occurs during the summer, return the Student Certification letter to EIP with the "Pending Student Certification" block marked. You must submit the letter from the institution by September 30 verifying that your child is a full-time student.

If EIP does not receive the letter by September 30, the child will lose eligibility for coverage on October 1. You will be able to add the child to your coverage again:

- At open enrollment
- Within 31 days of a special eligibility situation
- Within 31 days of the date the child returns to school full-time during the next semester.

If your dependent, age 19-24, goes back to school full-time, you may put him back on your health coverage. Within 31 days of eligibility, submit a Notice of Election (NOE) form and a statement on letterhead from the educational institution that verifies your dependent is a full-time student and gives his dates of enrollment. In this case, that would be the date he is again a full-time student.

If your child is not a full-time student, his eligibility for coverage ends the last day of the month in which he turns 19, unless he is covered as an incapacitated dependent. Your child's eligibility for coverage also ends if he gets married.

If your 19-year-old is certified as a full-time student **while he is in high school,** you must notify your benefits administrator or EIP within 31 days of the date he leaves high school.

When your child is covered as a full-time student, his eligibility for coverage ends the last day of the month in which he graduates, is no longer a full-time student, marries or turns age 25, unless he is covered as an incapacitated dependent. You must notify your benefits office that the child is no longer a full-time student and submit an NOE form dropping him from your coverage. If notification is received within 60 days of when coverage would have been lost due to the event, continuation of insurance under COBRA will be offered. Otherwise, it will not be offered.

EIP conducts periodic reviews of the eligibility of covered dependents ages 19-24. If your child is found to be ineligible, his coverage will be canceled, and EIP will seek repayment of any benefits paid for him while he was ineligible.

If a dependent whose eligibility is reviewed is a spring graduate of a community or technical college, a four-year college or a university and will return to school when the fall term begins, you will be asked to provide EIP with his application to the school he plans to attend or a letter of acceptance from the school he will attend.

Incapacitated Children

You can continue to cover your child, who is age 19 or older, if he is incapacitated and you are financially responsible for him. To cover your dependent child who is incapacitated, he must meet these requirements:

- The child must have been continuously covered by health insurance from the time of incapacitation.
- The child must be unmarried and must remain unmarried to continue eligibility.
- The child must be incapable of self-sustaining employment because of mental illness, retardation or physical disability and must remain principally dependent (more than 50 percent) on the covered employee, retiree, survivor or COBRA subscriber for support and maintenance.

Incapacitation must be established no earlier than 90 days before the child's 19th birthday but no later than 31 days after the date he is no longer covered as an eligible full-time student. An Incapacitated Child Certification Form must be completed by the subscriber and the child's physician and then sent to EIP for review. EIP will send the form to Standard Insurance Company for review of the medical information and for compliance with the Plan of Benefits. Additional medical documentation from the child's physician may be required by The Standard. The Standard will forward its recommendation to EIP, which makes the final decision.

If the child became incapacitated while enrolled as a full-time student, you must also include a letter from the school he was attending stating that he was a full-time student up to the date of incapacitation and that he is no longer a full-time student.

Also complete and attach an Authorized Representative Form signed by the incapacitated child. If applicable, you may forward a copy of guardianship papers from the probate court for your incapacitated child. Either of these documents gives EIP permission to discuss or disclose the child's protected health information with the child's Authorized Representative.

ENROLLMENT OF A TRANSFERRING EMPLOYEE

As an active employee, you are considered a transfer if you change employment from one participating group to another with no more than a 15 calendar-day break in employment or in insurance coverage.

As an **academic employee**, you are considered a transfer if you complete a school term and move to another participating academic employer at the beginning of the next school term. Your insurance coverage with the employer you are leaving will remain in effect until you begin work with your new employer, typically September 1. On that date, your new employer will pick up your coverage. If you do not transfer to another participating academic employer, your coverage ends the last day of the month in which you were actively at work.

A transfer is not considered a new hire for insurance purposes. When you transfer, you must remain enrolled in all of the same insurance programs in which you were enrolled at your former employer.

When you leave your job, tell your benefits administrator that you are transferring to another participating group. **Check with the benefits administrator at your new employer to ensure that your benefits have been transferred.**

LEAVE WITHOUT PAY

If you are an active employee, you can continue your coverage for up to 12 months if you are on leave without pay, as long as you pay the required premiums. Leave must be approved by your employer. *(For information on Family and Medical Leave or military leave, contact your benefits administrator.)*

WHEN YOU BECOME ELIGIBLE FOR MEDICARE

Medicare Before Age 65

If you or your covered dependent becomes eligible for Medicare before age 65 due to disability or end-stage renal disease (ESRD), the Social Security Administration will notify you. **You must notify EIP within 31 days of Medicare eligibility.** When you notify EIP, please submit a copy of your Medicare card.

If Medicare is your primary insurance, **you must enroll in Medicare Part B,** which helps cover doctors' services and outpatient hospital care. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs Part B would have paid.

Medicare at Age 65 When You Are Retired

The Social Security Administration should notify you or any dependents of Medicare eligibility approximately 90 days before turning 65 if you are receiving a Social Security check. If you are not notified, contact your local Social Security office immediately. If you are already receiving Social Security benefits when you turn 65, Medicare Part A will start automatically. Do not turn down Part B. If you do not enroll in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid. Even if you have not reached the age to qualify for full Social Security benefits, you should sign up for Medicare within three months of your 65th birthday.

For more information about enrolling in Medicare, see page 177.

If you are not receiving Social Security benefits when you turn 65 and you wish to wait to receive them until you reach full retirement age, you must contact the Social Security Administration to enroll in Medicare Part A and Part B. Medicare becomes your primary health insurance at age 65, regardless of whether you are receiving Social Security benefits.

Most Medicare recipients covered by health insurance plans offered through EIP should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under your health insurance.

IMPORTANT MEDICARE NOTE:

If you or one of your dependents become eligible for Medicare, you must notify EIP within 31 days of Medicare eligibility. **If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance,** when EIP discovers you are eligible for Medicare, EIP will:

- **Immediately begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your dependent(s) became eligible for Medicare.**

If You Are an Active Employee When You Turn 65

If you are actively working and/or covered under a state health plan for active employees when you turn 65, you may delay enrollment in Part B because your insurance as an active employee remains primary. However, if you are planning to retire within three months of age 65, you should contact Social Security to learn about your Medicare enrollment options. When you do retire, you should sign up for Part B within 31 days of retirement.

Medicare will then be your primary coverage, and you need Part A and Part B for full coverage. Do not turn down Medicare Part B coverage. If you are not enrolled in Part B at retirement, you will be required to pay the portion of your healthcare costs Part B would have paid.

If you are an active employee when your spouse turns 65, your spouse should enroll in Medicare Part A but may defer enrollment in Part B until you retire or leave covered employment.

Most Medicare recipients covered by health insurance plans offered through EIP should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under your health insurance.

WHEN YOUR COVERAGE ENDS

Your coverage will end:

- The last day of the month in which you were actively at work, unless you are transferring to another participating group
- The last day of the month in which you become ineligible for coverage (for example, your working hours are reduced from full-time to part-time)
- The day after your death
- The date the coverage ends for all employees or
- If you do not pay a required premium when it is due. (For example, if you are on leave without pay or on COBRA and are paying the full cost, you must make a monthly payment.)

Dependent coverage will end:

- The date your coverage ends
- The date dependent coverage is no longer offered or
- The last day of the month in which your dependent's eligibility for coverage ends.

If your coverage or your dependent's coverage ends, you may be eligible for continuation of coverage as a retiree, as a survivor or under COBRA. If you are dropping a dependent from your coverage, you must complete an NOE within 31 days of the date the dependent is no longer eligible for coverage.

COBRA

COBRA is short for Consolidated Omnibus Budget Reconciliation Act. It requires that continuation of **group health and/or dental insurance coverage** be offered to you and/or your covered dependents if you are no longer eligible for coverage due to a qualifying event. Qualifying events include:

- The covered employee's working hours are reduced from full-time to part-time
- The covered employee voluntarily quits work, retires, is laid off or is fired (unless the firing is due to gross misconduct)
- The covered employee is separated or divorced from his spouse
- A covered child no longer qualifies as a dependent.

For covered dependents to continue coverage under COBRA, the subscriber or a dependent must notify his benefits office **within 60 days of the qualifying event or the date coverage would have been lost due to the qualifying event,** whichever is later. Otherwise, the individual will lose his rights to COBRA coverage.

To begin coverage under COBRA, a COBRA Notice of Election and premiums must be submitted. The premiums must be paid within 45 days of the date coverage was elected. Your first premium payment must include premiums for the month following the date you lost coverage, the month you elected coverage and the first full month of COBRA coverage.

For example: You lost coverage on June 30 and then elected coverage on August 15. You would be required to pay three premiums: one for the month following the date you lost coverage; one for the month in which you elected coverage; and one for the first full month after you elected coverage.

COBRA coverage becomes effective when the first premium is paid and remains in effect only as long as the premiums are kept up-to-date. EIP is the benefits administrator for COBRA subscribers of state agencies, college and universities and school districts. COBRA subscribers from local subdivisions keep the same benefits administrator.

If you need more information about COBRA, contact your benefits office or EIP.

When COBRA Benefits Run Out

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees that persons who have exhausted COBRA benefits and are not eligible for coverage under another group health plan have access to health insurance coverage without being subject to a pre-existing condition exclusion period. However, certain conditions must be met. In South Carolina, the South Carolina Health Insurance Pool provides this guarantee of health insurance coverage. For information, call 803-788-0500, ext. 46401 (Greater Columbia area) or 800-868-2500, ext. 46401 (toll-free outside the Columbia area).

DEATH OF A SUBSCRIBER OR A COVERED DEPENDENT

If an active employee or a retiree of a local subdivision dies, a family member should contact the deceased's employer to report the death, to discontinue the employee's health and dental coverage and start survivor coverage for any covered dependents. If a state agency, college or university or school district retiree dies, a family member should contact EIP.

If one of your dependents dies, please contact your benefits administrator. (The Employee Insurance program is the benefits administrator for retirees of state agencies, colleges and universities and school districts. Survivor subscribers of local subdivisions keep the same benefits administrator.)

Survivors

Spouses and children who are covered as dependents under the State Health Plan or an HMO are eligible as survivors for a one-year waiver of health insurance premiums when a covered employee or a funded retiree dies.

Participating local subdivisions may elect to, but are not required to, waive the premiums of survivors of retirees. Retirees of a participating local subdivision should check with their benefits administrator to see whether the waiver applies.

After the premium has been waived for a year, a survivor must pay the full premium to continue coverage. If you and your spouse are both covered employees or retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

If you are a covered spouse or dependent child of a covered employee who was killed in the line of duty while working for a participating group, your premium will be waived for the first year after the employee's death. You must submit verification of death in the line of duty. After the one-year waiver, if you are a covered survivor of a state agency or a school district employee you may continue coverage, *at the employer-funded rate*, as long as you are eligible. Participating local subdivisions may elect to, but are not required to, contribute to your insurance premium, but you may continue coverage, at the full rate, for as long as you are eligible.

For a list of steps to follow when a loved one dies, see page 25.

State Dental Plan and Dental Plus premiums are not waived. However, survivors can continue dental coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. Contact EIP for details.

As long as a survivor remains covered by health or dental insurance, he can add either at open enrollment. If he has health and dental and drops both, he is no longer eligible as a survivor and cannot re-enroll in coverage, even at open enrollment.

If a survivor becomes an active employee of a participating employer, he can switch to active coverage. When he leaves active employment, he can go back to survivor coverage.

WORKERS' COMPENSATION

Insurance offered through EIP is not meant to replace Workers' Compensation and does not affect any requirement for coverage for Workers' Compensation insurance. It is not intended to provide or duplicate benefits for work-related injuries that are within the Workers' Compensation Act. If you need more information, please contact your benefits office or EIP.

COORDINATION OF BENEFITS

Some families in which one spouse works for a participating employer and the other works for an employer that is not covered through EIP are eligible to enroll in two health plans. While the additional coverage may mean that more of your medical expenses are paid by insurance, you probably pay premiums for both plans. Weigh the advantages and disadvantages carefully before you purchase extra coverage.

Most health plans have a system to determine how claims are handled when a person is covered under more than one insurance plan. This is called "coordination of benefits" (COB). When a subscriber has coverage under more than one plan, he can file a claim for reimbursement from each plan. Third-party administrators,

such as BlueCross BlueShield of South Carolina or your HMO, coordinate benefits so that you get the maximum reimbursement allowed. That amount will never be more than 100 percent of your covered medical, dental or prescription drug expenses.

There are rules that determine the order in which the plans pay benefits. The plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. Here are some examples of how that works:

- The plan that covers a person as an employee is primary to the plan that covers the person as a dependent.
- When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is primary. Other rules may apply in special situations, such as when a child's parents are divorced.
- If you are eligible for Medicare and are covered as an active employee, your State Health Plan or HMO coverage is primary over Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.

For more information about how coordination of benefits works, see the section on your health plan.

PREVENTION PARTNERS

Prevention Partners, a unit of the Employee Insurance Program, is designed to help you and your family lead healthier lives. Its activities, programs and services promote good health through disease prevention, early detection of disease and chronic disease education.

A major initiative of Prevention Partners is the Preventive Worksite Screening. This comprehensive health screening measures cholesterol levels, blood pressure, triglyceride levels, kidney function and red and white blood cell counts. These measurements indicate if an employee is at risk for developing hypertension, diabetes and anemia.

This benefit is available for only $15 to active and retired employees and their covered spouses whose primary insurance coverage is the Standard Plan, the Savings Plan, BlueChoice HealthPlan, CIGNA HMO or MUSC Options.

The cost of the Preventive Worksite Screening does not contribute toward your annual deductible or out-of-pocket maximum.

Chronic Disease Workshops, another major program, give subscribers and their dependents information they need to help them take better care of themselves. Workshops include: Caregivers, Diabetes, Heath Disease, Asthma, Kidney Evaluation, Women's Reproductive Health, Weight Management, Medications, Men's Health, Cholesterol/Lipids and Gastrointestinal Ailments.

In 2002, the Budget and Control Board's Office of Research and Statistics compared 196 State Health Plan subscribers who attended a Diabetes Management Workshop between 1995 and 1999 with a group of subscribers who did not. During a two-year period, the medical and drug claims of the group that attended the workshop were $2,123.99 per person less than those who did not. The study indicates participants in the workshop were doing a better job controlling the risks of complications of their disease.

Other Prevention Partners programs include:

- Spring Wellness Walk
- Lifestyle change workshops on lowering risk factors, weight loss and exercise
- Worksite program consultation
- Volunteer Worksite Prevention Partners coordinator network and conferences
- Prevention Partners training workshops
- Preventive Worksite Immunization (influenza).

For more information on Prevention Partners, contact your benefits office, your Prevention Partners coordinator or call 803-737-3820 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area). You also can go to the EIP Web site at www.eip.sc.gov. Then click on "Prevention Partners," which is on the left side of your screen.

THE VISION CARE PROGRAM

This program offers you discounted vision care services. Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than $60[1] for a routine, comprehensive eye examination. If you are fitted for contact lenses, you may pay more because that can require additional services. Participating providers, who include opticians, have agreed to give a 20-percent[1] discount on all eyewear except disposable contact lenses.

[1]*These amounts can change yearly. Contact your benefits office, provider or EIP for the current amounts.*

If you are covered by more than one vision care program, you can take advantage of the discounts offered under this program or the benefits offered through your other coverage, but you cannot use both at the same time.

The eye examination should include at least these tests and services:

- Complete eye and medical history review
- Visual acuity far and near, with and without glasses
- Tonometry
- Screening visual fields
- Refraction
- External motility, biomicroscopic and dilated
- Ophthalmoscopic examinations
- Initiation of diagnostic and treatment programs as necessary, including prescription of lenses, medication and other therapy, arranging for special diagnostics or treatment services, consultations, laboratory procedures or radiological services as may be indicated.

Treatment must be within the scope of the license of the provider. Consult your eye care provider for details on any of these services.

You may participate in this program if you are a full-time or part-time employee, retiree, survivor or COBRA participant. Your dependents also are eligible. You do not have to be enrolled in the State Health Plan or a health maintenance organization. It is your responsibility to show your provider some type of employment-related identification to prove you are eligible for the Vision Care Program. If you do not, you may not receive the discount.

Providers Are Available Statewide

To see the list of participating providers, go to the Employee Insurance Program's Web site, www.eip.sc.gov. Click on "Choose Your Category" and then select your category (Active Subscribers, Retirees, etc.). Next, choose "Online Directories" and then select "Vision Care." You can search for providers by county or by state. This is the most up-to-date list.

If your provider is not listed, you may wish to ask if he gives discounts through the state's Vision Care Program. If your provider would like to be part of the program, he should call the Employee Insurance Program. Although EIP lists providers who participate in the program, the state does not recommend any specific eye care provider.

If you do not have access to the Internet, ask your benefits administrator to print a copy of the list for you. You can also request one by writing to EIP at P.O. Box 11661, Columbia, SC 29211, or by calling 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

No Claims to File

The Vision Care Program is a discount program. You do not file claims and will not receive reimbursement for routine eye examinations or eyewear, including contacts. Active employees who have a MoneyPlu$ Medical Spending Account or a limited use Medical Spending Account can file a reimbursement claim with MoneyPlu$ for vision care expenses.

If you have questions about this program, please contact your benefits office or EIP.

THE INTERNET PROVIDES EASY ACCESS TO YOUR INSURANCE INFORMATION

Like many organizations, the Employee Insurance Program offers helpful information through the Internet. Two places to find it are *EIP Direct* and the EIP Web site.

EIP Direct is a bimonthly newsletter sent to your benefits administrator, who may send you the information or the newsletter itself. The newsletter gives you information about changes in benefits, answers questions about benefits and tells you about programs that may be of interest to you, such as Prevention Partners chronic disease workshops. *EIP Direct* can be viewed on the EIP Web site, www.eip.sc.gov. Choose "News & Updates" and then "Newsletters."

The Web site is also the place to find other ideas about how to make the best use of your insurance, as well as links to the Web sites of EIP's third-party administrators. When you go to www.eip.sc.gov, you will see a bar across the top of the home page. It has several tabs, including:

- FAQ (general information, as well as questions about the Savings Plan and HSAs)
- News and Updates (includes a tab that takes you to "Newsletters," such as *EIP Direct* and *Avenues*)
- Links (direct access to companies that administer EIP programs).

When you select "Choose Your Category," which is on the left, you will see a list of the types of subscribers served by EIP. Most of you are "Active Subscribers," or employees. When you click on your category, you will receive a list of choices. They include "Eligibility," "Forms," "On-line Directories" (lists of providers that are part of the health plan networks) and "Rates." Click on "Publications" to see a list that includes this benefits guide. You can use the "binoculars" search feature to help you find specific topics in the guide.

"Prevention Partners" is one of the choices listed on the left side of our home page. Click on it for ways to improve your health. Under "Early Detection," for example, you will find a list of the regional Worksite Screenings.

"Insurance Managers" provides direct links to the Web sites of the third-party administrators. These sites give you access to your account information, including claim status, verification of authorization for inpatient and outpatient visits and Explanations of Benefits.

If you need assistance or, additional information or would like to make a suggestion, click on "Need Customer Service?" to send EIP an e-mail.

MyBenefits — EIP's Online Enrollment System

Access to your benefits information is just a click away with MyBenefits, the Employee Insurance Program's (EIP) online enrollment system. Through MyBenefits, you can update your beneficiaries and contact information and print a copy of your benefits statement anytime you have access to the Internet – 24 hours a day, seven days a week. During the enrollment period each October, you can make your own coverage changes.

At this time, MyBenefits is available only to active employees.

The system is convenient and easy to use. To get started with MyBenefits, go to the EIP Web site, www.eip.sc.gov, and select the "MyBenefits" button on the left. If you are a first-time user, you must register. The federal Health Insurance Portability and Accountability Act (HIPAA) requires that insurance programs protect the confidentiality of subscribers' health information. As part of this effort, you need to answer four questions and create a password when you register to use MyBenefits. After you register, you will be shown a screen listing your password and your answers to the questions. **Print the information on the screen, and keep it in a safe place.**

Information about how to use MyBenefits is offered as you work through the program. During enrollment periods, a tutorial will be available, and links to written instructions will accompany each section.

APPEALS

What If I Disagree With A Decision About Eligibility?

This section contains a summary of the eligibility rules for benefits offered through the Employee Insurance Program (EIP). Eligibility determinations are subject to the provisions of the Plan of Benefits documents.

If you are dissatisfied after an eligibility determination has been made, you may ask EIP to review the matter by making a written request to EIP within 90 days of notice of the decision. If the decision is upheld by EIP, you have 30 days to seek judicial review in the S.C. Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.

CHECKLISTS: QUICK GUIDES TO YOUR BENEFITS

These lists will help you quickly locate information in the *Insurance Benefits Guide* when you find yourself in a new situation.

RETIREE CHECKLIST

Before you retire, review your benefits. The Employee Insurance Program (EIP) sends you a copy of your benefits statement each September. You can also obtain a copy from MyBenefits, the online enrollment system. Go to the EIP Web site, www.eip.sc.gov, and click on the "MyBenefits" button. After you log in, click on "Review Benefits."

Eligibility

- Before you set your retirement date, check with your benefits administrator to see if you are eligible to continue your insurance. See page 171.

Funding

- Find out if your employer will pay part of your health insurance premium. See page 171.

Enrollment

- You must complete a Retiree Notice of Election form and an Employment Verification Record within 31 days of your retirement date. See page 173.

Returning to Work

- If you plan to return to work for a participating employer after you retire, see page 175.

Benefits Choices

- **Health –**Your health plan choices as a retiree depend on whether you are eligible for Medicare. To learn what your choices are, see pages 174-175. For premiums, see pages 210-211.
- Notify your benefits administrator within 31 days of the date you, or a dependent you cover, become eligible for **Medicare. Enroll in Part A and Part B**. In most cases, you should **not** enroll in Part D. For details, see page 177.
- **Dental –**You are eligible for the State Dental Plan and Dental Plus. For benefits information, see page 192. For premiums, see pages 210-211.
- **MoneyPlu$ –**Your eligibility ends at retirement. For details, see page 192.
- **Long Term Care –**You can continue, or may be eligible to enroll in, Long Term Care coverage. See page 192.
- **Life Insurance –**You may continue your **Basic Life, Optional Life** and **Dependent Life** insurance. For details, see page 193.
- **Long Term Disability –**Your **Basic Long Term Disability** insurance ends with retirement. You may continue **Supplemental Long Term Disability** coverage under certain circumstances. For details, see page 194.

Your Benefits Administrator in Retirement

- If you worked for a state agency, a college or university or a public school district, EIP will become your benefits administrator.
- If you worked for a local subdivision, your benefits administrator will remain the same.

SURVIVOR CHECKLIST

It is never easy when a loved one dies. We hope this list of steps to follow will help you during this difficult time.

Contacts

If the deceased was a retiree of a state agency, college, university or school district, or one of their covered dependents:
- Notify the Employee Insurance Program (EIP).

If the deceased was an active employee, a retiree of a local subdivision or one of their covered dependents:
- Notify the subscriber's employer.

When Coverage Ends for the Deceased

- If the deceased was enrolled in health, dental, Long Term Care and/or Long Term Disability coverage, this coverage ends the day after death.

Health and Dental Insurance

Please read the "Survivors" section on page 19.
- Spouses or children who were covered as dependents under the State Health Plan or an HMO can continue coverage as survivors. They may also be eligible for a one-year waiver of health insurance premiums.
- Survivors may continue dental coverage, but the premium is not waived.

Life Insurance

A certified, raised-seal death certificate is needed to apply for benefits from The Hartford. See page 114.
- Basic Life insurance, $3,000, is provided to all full-time, active employees enrolled in a health insurance program. See page 105.
- If the deceased was covered by Optional Life insurance, see page 111.
- If the deceased was covered by Dependent Life insurance, see page 118.
- The Beneficiary Assist® Program is free and available to beneficiaries of Basic, Optional and Dependent Life policies. See page 120.
- If the deceased was retired and his last employer before retirement participates in the Retiree Group Life Insurance program, he may be eligible for a benefit based on his retirement-credited service in the S.C. Retirement Systems (SCRS). Contact SCRS for more information.

Long Term Care Insurance

- If the deceased was an active employee when he enrolled in Long Term Care, his beneficiary may receive a return of contributions minus any claim dollars paid. The beneficiary of a deceased spouse also may be eligible. Some restrictions may apply. For details see page 142 and contact Aetna.

Supplemental Long Term Disability Insurance

- If the deceased was receiving Supplemental Long Term Disability benefits provided by the Standard Insurance Company, survivor benefits may be payable to the eligible survivor in a lump-sum payment. See page 137.

MoneyPlu$

- If the deceased had a MoneyPlu$ Health Savings Account, contact NBSC about settling the account. See pages 167; 233, Article VII.
- Medical Spending Accounts (MSA) and Dependent Care Accounts (DCA) end on the date the employee died. See page 166.